



Therapy Services



*Physical Therapy, Occupational
Therapy and Speech Therapy*



*Medicaid and Other Medical
Assistance Programs*

This publication supersedes all previous Physical Therapy, Occupational Therapy and Speech Therapy handbooks. Published by the Montana Department of Public Health & Human Services, August 2004.

| *Updated April 2005, August 2005.*

CPT codes, descriptions and other data only are copyright 1999 American Medical Association (or such other date of publication of CPT). All Rights Reserved. Applicable FARS/DFARS Apply.

My Medicaid Provider ID Number:

My CHIP Provider ID Number:

Table of Contents

Table of Contents	i.1
Key Contacts	ii.1
Introduction.....	1.1
Manual Organization and Maintenance	1.1
Rule References	1.1
Claims Review (MCA 53-6-111, ARM 37.85.406)	1.2
Getting Questions Answered	1.2
Covered Services	2.1
General Coverage Principles	2.1
Services within scope of practice (ARM 37.86.606)	2.1
Services provided by therapists (ARM 37.86.601-605, 37.85.402)	2.1
Non-covered services (ARM 37.85.207 and 37.86.606)	2.2
Verifying coverage	2.3
Therapy Service Requirements (ARM 37.86.606)	2.4
Order/referral	2.4
Documentation	2.4
Coverage of Specific Services	2.5
Augmentative communications devices	2.5
Maintenance therapy plan	2.5
Occupational, physical, and speech therapy	2.5
Splints, braces, and slings	2.6
Other Programs	2.6
Mental Health Services Plan (MHSP)	2.6
Children's Health Insurance Plan (CHIP)	2.6
Prior Authorization and PASSPORT	3.1
What Are PASSPORT, Team Care and Prior Authorization? (ARM 37.85.205 and 37.86.5101 - 5120).....	3.1
How to Identify Clients on PASSPORT	3.2
How to Obtain PASSPORT Approval	3.2
PASSPORT and Indian Health Services	3.2
Getting questions answered	3.2
Prior Authorization	3.3
Coordination of Benefits	4.1
When Clients Have Other Coverage.....	4.1
Identifying Additional Coverage	4.1
When a Client Has Medicare	4.1
Medicare Part B crossover claims	4.2

When a Client Has TPL (ARM 37.85.407)	4.3
Exceptions to billing third party first	4.3
Requesting an exemption	4.3
When the third party pays or denies a service	4.4
When the third party does not respond	4.4
Billing Procedures	5.1
Claim Forms	5.1
Timely Filing Limits (ARM 37.85.406)	5.1
Tips to avoid timely filing denials	5.1
When To Bill Medicaid Clients (ARM 37.85.406)	5.2
Client Cost Sharing (ARM 37.85.204 and 37.85.402)	5.3
When Clients Have Other Insurance	5.3
PASSPORT Billing Tips	5.4
Billing for Retroactively Eligible Clients	5.4
Place of Service	5.4
Therapists Employed by Nursing Facilities, Hospitals or Home Health Agencies	5.4
Billing for Evaluations	5.5
Coding	5.5
Using the Medicaid Fee Schedule	5.6
Using Modifiers	5.7
Bundled services	5.7
Submitting a Claim	5.7
The Most Common Billing Errors and How to Avoid Them	5.7
Submitting a Claim	6.1
Electronic Claims	6.1
Billing electronically with paper attachments	6.1
Paper Claims	6.2
CMS-1500 Agreement	6.13
Avoiding Claim Errors	6.14
Remittance Advices and Adjustments	7.1
The Remittance Advice	7.1
Electronic RA	7.1
Paper RA	7.1
Key to the Paper RA	7.4
Credit balance claims	7.5
Rebilling and Adjustments	7.5
How long do I have to rebill or adjust a claim?	7.5
Rebilling Medicaid	7.5
When to rebill Medicaid	7.5
How to rebill	7.6
Adjustments	7.6
When to request an adjustment	7.6
How to request an adjustment	7.7
Completing an Adjustment Request Form	7.7

Key Contacts

Hours for Key Contacts are 8:00 a.m. to 5:00 p.m. Monday through Friday (Mountain Time), unless otherwise stated. The phone numbers designated “In state” will not work outside Montana.

Provider Enrollment

For enrollment changes or questions:

(800) 624-3958 In and out-of-state
(406) 442-1837 Helena

Send written inquiries to:

Provider Enrollment Unit
P.O. Box 4936
Helena, MT 59604

Provider Relations

For questions about eligibility, payments, denials, general claims questions, PASSPORT questions, or to request provider manuals, fee schedules:

(800) 624-3958 In and out-of-state
(406) 442-1837 Helena

Send written inquiries to:

Provider Relations Unit
P.O. Box 4936
Helena, MT 59604

Claims

Send paper claims to:

Claims Processing Unit
P. O. Box 8000
Helena, MT 59604

Direct Deposit Arrangements

Providers who would like to receive their remittance advices electronically and electronic funds transfer should call the number below.

(406) 444-5283

Third Party Liability

For questions about private insurance, Medicare or other third-party liability:

(800) 624-3958 In and out-of-state
(406) 442-1837 Helena
(406) 442-0357 Fax

Send written inquiries to:

Third Party Liability Unit
P. O. Box 5838
Helena, MT 59604

PASSPORT Client Help Line

Clients who have general Medicaid questions may call the Client Help Line:

(800) 362-8312

Send written inquiries to:

PASSPORT To Health
P.O. Box 254
Helena, MT 59624-0254

Provider's Policy Questions

For policy questions, contact the appropriate division of the Department of Public Health and Human Services; see the *Introduction* chapter in the *General Information For Providers* manual.

Client Eligibility

For client eligibility, see the *Client Eligibility and Responsibilities* chapter in the *General Information For Providers* manual.

EDI Technical Help Desk

For questions regarding electronic claims submission:

(800) 987-6719 In and out-of-state
(406) 442-1837 Helena
(406) 442-4402 Fax

Mail to:

ACS
 ATTN: MT EDI
 P.O. Box 4936
 Helena, MT 59604

Secretary of State

The Secretary of State's office publishes the most current version of the Administrative Rules of Montana (ARM):

(406) 444-2055 Phone

Secretary of State
 P.O. Box 202801
 Helena, MT 59620-2801

Prior Authorization

Surveillance/Utilization Review

For prior authorization for certain services (see the *PASSPORT and Prior Authorization* chapter in this manual), contact SURS:

For clients with last names beginning with A - L, call:

(406) 444-3993 Phone

For clients with last names beginning with M - Z, call:

(406) 444-0190

Information may be faxed to:

(406) 444-0778 Fax

Send written inquiries to:
 Surveillance/Utilization Review
 2401 Colonial Drive
 P.O. Box 202953
 Helena, MT 59620-2953

Covered Services

General Coverage Principles

This chapter provides covered services information that applies specifically to services performed by independent physical, occupational and speech therapists. Therapists that are employed by a facility (e.g., hospitals, nursing facilities, home health agencies, etc.) should refer to the corresponding provider manual for requirements and billing procedures, which may vary. Like all health care services received by Medicaid clients, services rendered by these providers must also meet the general requirements listed in the *Provider Requirements* chapter of the *General Information For Providers* manual.

Services within scope of practice (ARM 37.86.606)

Services are covered only when they are within the scope of the provider's license as permitted by state law.

Services provided by therapists (ARM 37.86.601-605, 37.85.402)

Therapy providers must maintain current licensure to practice from the state in which they are practicing. Providers must also be enrolled as Montana Medicaid providers. An assistant or aide may not enroll as a Medicaid provider. Providers cannot submit claims for services they did not provide, except for services provided by therapy assistants or aides. Services performed by an assistant or aide in accordance with Title 37 MCA must have their services billed to Medicaid under the licensed supervising therapist's Medicaid provider number. The levels of supervision are as follows:

- General: Procedure is furnished under the licensed provider's direction and control, but the licensed provider's presence is not required during the performance of the procedure.
- Direct: The licensed provider must be present in the office and immediately available to furnish assistance and direction throughout the performance of the procedure. The licensed provider must be in the direct treatment area of the client-related procedure being performed.
- Routine: The licensed provider must provide direct contact at least daily at the site of work, within interim supervision occurring by other methods, such as telephonic, electronic or written communication.
- Temporary Practice Permit holders (new grads from occupational therapy school who are waiting for their national exam results) MUST work under ROUTINE supervision of the licensed therapist. If the exam is failed the Temporary Practice Permit IMMEDIATELY becomes VOID. Routine supervision requires direct contact at least daily at the site of work.



Only
licensed
therapists
may enroll
as Montana
Medicaid
providers.

- Occupational and Speech Therapy Aides require personal, direct supervision by the licensed provider. This means the licensed provider must be face to face with the aide in the same room when procedures are being provided.
- Speech Therapy Aides:
 - Aide 1 = supervised a minimum of 30% while performing diagnostic and interpretive functions in the first year of non-allowable activities. The supervision requirement will be 5% of client contact time, of which 2% shall be direct contact after the first year, at the discretion of the supervising speech-language pathologist
 - Aide 2 = shall be supervised 10% of client contact time, of which 5% shall be direct contact
 - Aide 3 = shall be supervised 20% of client contact time, of which 5% shall be direct contact. Refer to ARM 24.222.702
- Occupational Therapy Assistants require general supervision, meaning the licensed provider does not have to be physically on the premises at the time of the service. However, the licensed therapist must provide face to face supervision at least monthly.
- Physical Therapy Aides/Assistants require general supervision, meaning that the licensed provider must be on the premises.
- Temporarily licensed therapists can never supervise anyone.

Providers must notify Provider Relations (see *Key Contacts*) of any changes to their status (e.g. address change, licensure status, or change in ownership of medical practice).

Non-covered services (ARM 37.85.207 and 37.86.606)

Some services not covered by Medicaid include but are not limited to the following:

- Maintenance therapy services (may be covered under the Home and Community Based Services [HCBS] program; refer to the HCBS manual)
- Services that do not require the performance or supervision of a licensed therapist, even if the services are performed by the therapist
- A therapist's time for the following:
 - Attending client care meetings
 - Client-related meetings with other medical professionals or family members
 - Completion of paperwork or reports
- Observation
- Acupuncture

- Naturopath services
- Masseur or Masseuse services
- Services considered experimental or investigational
- Services provided to Medicaid clients who are absent from the state, with the following exceptions:
 - Medical emergency
 - Required medical services are not available in Montana. Prior authorization may be required; see the *PASSPORT and Prior Authorization* chapter in this manual.
 - If the Department has determined that the general practice for clients in a particular area of Montana is to use providers in another state
 - When out-of-state medical services and all related expenses are less costly than in-state services
 - When Montana makes adoption assistance or foster care maintenance payments for a client who is a child residing in another state
- Medicaid does not cover services that are not direct patient care such as the following:
 - Missed or canceled appointments
 - Mileage and travel expenses for providers
 - Preparation of medical or insurance reports
 - Service charges or delinquent payment fees
 - Telephone services in home
 - Remodeling of home
 - Plumbing service
 - Car repair and/or modification of automobile

Verifying coverage

The easiest way to verify coverage for a specific service is to check the Department's fee schedule for your provider type. In addition to being listed on the fee schedule, all services provided must also meet the coverage criteria listed in the *Provider Requirements* chapter of the *General Information For Providers* manual and in this chapter. Use the current fee schedule in conjunction with the more detailed coding descriptions listed in the current CPT-4 and HCPCS Level II coding books. Take care to use the fee schedule and coding books that pertain to the date of service.

Current fee schedules are available on the *Provider Information* web site, disk, or hardcopy. For disk or hard copy, contact Provider Relations (see *Key Contacts*).



Use the current fee schedule for your provider type to verify coverage for specific services.



An order/referral is valid for 180 days from the day the therapist receives it.

Therapy Service Requirements (ARM 37.86.606)

Medicaid covers restorative therapy services when they are reasonable and necessary to the treatment of the client's condition and result in improved function. The amount and frequency of services provided must be within the therapy's generally accepted standard of practice. Therapy services are not restorative if the client's expected restoration potential is insignificant in relation to the extent and duration of services required. Therapy services are no longer restorative when it is determined that function will not improve. All therapy services require an order or referral from the client's physician or mid-level practitioner and documentation on the client's progress. Some services may also require prior authorization or PASSPORT provider approval before they are provided (see the *PASSPORT and Prior Authorization* chapter in this manual).

Order/referral

Therapy services may be provided to a client when a current written or verbal order/referral has been received from the client's physician or mid-level practitioner. The therapy provider is responsible for obtaining the order/referral before providing services. Medicaid does not cover services provided before obtaining an order/referral. When the order/referral is verbal, the client's physician or mid-level practitioner must supply the therapist with the same order/referral in writing within 30 days of the verbal order/referral. The therapist should document in his or her records a verbal order/referral was provided by the client's physician or mid-level practitioner. The written order/referral must be signed and dated by the referring physician or mid-level practitioner. The Department considers an order/referral valid for no more than 180 days from the time the therapist receives the order/referral from the physician or mid-level practitioner. When a client is enrolled in the PASSPORT To Health Program, a PASSPORT approval is required and the referral number must be included on the claim (see the *PASSPORT and Prior Authorization* chapter in this manual).

Documentation

Providers must maintain records that demonstrate compliance with Medicaid requirements. General record keeping requirements are described in the *General Information For Providers* manual, *Provider Requirements* chapter. All therapy case records must be current and available upon request from the Department. Case records must contain at least the following:

- Signed and dated order/referral from the client's physician or mid-level practitioner
- Client's name on each page of documentation
- Diagnosis, duration and time, course of treatment and expected outcomes
- Therapist treatment for each session
- Client's progress in meeting therapy goals to ensure therapy services are still restorative and not maintenance

- Support time spent for each procedure billed. Time should be indicated in the record, whether a start/end time documented at each visit or total time spent with the client at the visit.
- Documentation must be complete and representative of what the therapist has provided each time a client is seen and must support the procedures that are billed to Medicaid.
- Records signed and dated by the treating therapist

Coverage of Specific Services

The following are coverage rules for specific services provided by physical, occupational and speech therapists. The Medicaid payment includes all related supplies and items used when providing therapy services, except for splints, braces, and slings, which are discussed later.

Augmentative communications devices

Medicaid covers augmentative communications devices when they are prior authorized. The Department's policy is to rent the communications device for eight weeks prior to purchase. For instructions on obtaining prior authorization, see the *PASSPORT and Prior Authorization* chapter in this manual.

Maintenance therapy plan

Medicaid covers the development of a maintenance therapy plan by a licensed therapist. The maintenance plan must include all of the following:

- The client's initial evaluation
- Development of a plan that incorporates the prescribing physician's or mid-level practitioner's treatment objectives and is appropriate for the client's capacity and tolerance
- Instructions for others in carrying out the plan and further evaluations by a licensed therapist as required

Occupational, physical, and speech therapy

Medicaid covers a maximum of 40 hours of each type of therapy (i.e., occupational, physical and speech) for clients ages 21 and older during a fiscal year (July 1 - June 30). The payment system calculates the respective units/hours of therapy services as claims adjudicate. The system will calculate a procedure that has "each 15 minutes" in the description as one unit; four units equals one hour. A procedure code that does not have a delineated time unit is counted as one hour within the system, whether the service takes 30 minutes or three hours. When the limit on units or hours is reached for the respective therapy service, any additional claims are denied. Provider Relations can verify the number of therapy hours that have been processed for a client, but this amount would not include any outstanding claims (e.g., claims waiting to be keyed or therapy claims submitted by other providers).

The Early and Periodic Screening, Diagnosis and Treatment Program (EPSDT) covers all medically necessary services for children age 20 and under. Therapy services for children are not restricted to a specific number of hours or units as long as the therapy services are restorative, not maintenance. All other applicable requirements apply (e.g., current order/referral, provider requirements, prior authorization requirements, and PASSPORT approval). See the *PASSPORT and Prior Authorization* chapter in this manual.

Splints, braces, and slings

Medicaid covers the design, fabrication, fitting and instruction by a licensed therapist in the use of splints, braces and slings under the Durable Medical Equipment (DME) program. Therapists must be enrolled with Medicaid as DME providers in order to bill for these services. If a therapist is also enrolled as a DME provider, he or she must abide by the rules/policies set forth by the DME program.

Other Programs

This is how the information in this manual applies to Department programs other than Medicaid.

Mental Health Services Plan (MHSP)

The information in this manual does not apply to the Mental Health Services Plan (MHSP). For more information on the MHSP program, see the *Mental Health Manual* available on the Provider Information website (see *Key Contacts*).

Children's Health Insurance Plan (CHIP)

The information in this manual does not apply to CHIP clients. For a CHIP medical manual, contact BlueCross BlueShield of Montana at (800) 447-7828 x8647. Additional information regarding CHIP is available on the CHIP website (see *Key Contacts*).

Submitting a Claim

Electronic Claims

Professional claims submitted electronically are referred to as ANSI ASC X12N 837 transactions. Providers who submit claims electronically experience fewer errors and quicker payment. Claims may be submitted electronically by the following methods:

- **ACS field software WINASAP 2003.** ACS makes available this free software, which providers can use to create and submit claims to Montana Medicaid, MHSP, and CHIP (dental and eyeglasses only). It does not support submissions to Medicare or other payers. This software creates an 837 transaction, but does not accept an 835 (electronic RA) transaction back from the Department. The software can be downloaded directly from the ACS EDI Gateway website. For more information on WINASAP 2003, visit the ACS EDI Gateway website, or call the number listed in the *Key Contacts* section of this manual.
- **ACS clearinghouse.** Providers can send claims to the ACS clearinghouse (ACS EDI Gateway) in X12 837 format using a dial-up connection. Electronic submitters are required to certify their 837 transactions as HIPAA-compliant before sending their transactions through the ACS clearinghouse. EDIFICS certifies the 837 HIPAA transactions at no cost to the provider. EDIFICS certification is completed through ACS EDI Gateway. For more information on using the ACS clearinghouse, contact ACS EDI Gateway (see *Key Contacts*).
- **Clearinghouse.** Providers can contract with a clearinghouse so that the provider can send the claim to the clearinghouse in whatever format the clearinghouse accepts. The provider's clearinghouse then sends the claim to the ACS clearinghouse in the X12 837 format. The provider's clearinghouse also needs to have their 837 transactions certified through EDIFICS before submitting claims to the ACS clearinghouse. EDIFICS certification is completed through ACS EDI Gateway.

Providers should be familiar with the *Implementation Guides* that describe federal rules and regulations and provide instructions on preparing electronic transactions. These guides are available from the Washington Publishing Company (see *Key Contacts*). *Companion Guides* are used in conjunction with *Implementation Guides* and provide Montana-specific information for sending and receiving electronic transactions. They are available on the ACS EDI Gateway website (see *Key Contacts*).

Billing electronically with paper attachments

When submitting claims that require additional supporting documentation, the *Attachment Control Number* field must be populated with an identifier. Identifier formats can be designed by software vendors or clearinghouses, but the preferred method is the provider's Medicaid ID number followed by the client's ID number and the date of service, each separated by a dash:

9999999 - 888888888 - 11182003
 Medicaid Client ID Date of
 Provider ID Number Service
 (mmddyyyy)

The supporting documentation must be submitted with a paperwork attachment cover sheet (located on the Provider Information website and in *Appendix A: Forms*). The number in the paper *Attachment Control Number* field must match the number on the cover sheet. For more information on attachment control numbers and submitting electronic claims, see the *Companion Guides* located on the ACS EDI website (see *Key Contacts*).

Paper Claims

The services described in this manual are billed on CMS-1500 claim forms. Claims submitted with all of the necessary information are referred to as “clean” and are usually paid in a timely manner (see the *Billing Procedures* chapter in this manual).

Claims are completed differently for the different types of coverage a client has. This chapter includes instructions and a sample claim for each of the following scenarios:

- Client has Medicaid coverage only
- Client has Medicaid and Medicare coverage
- Client has Medicaid and third party liability coverage
- Client has Medicaid, Medicare, and third party liability coverage
- Client has Medicaid, Medicare, and Medicare supplement coverage

When completing a claim, remember the following:

- Required fields are indicated by “*”.
- Fields that are required if the information is applicable to the situation or client are indicated by “**”.
- Field 24h, *EPSDT/family planning*, is used as an indicator to specify additional details for certain clients or services. The following are accepted codes:

EPSDT/Family Planning Indicators		
Code	Client/Service	Purpose
1	EPSDT	This indicator is used when the client is under age 21
2	Family planning	This indicator is used when providing family planning services.
3	EPSDT and family planning	This indicator is used when the client is under age 21 and is receiving family planning services
4	Pregnancy (any service provided to a pregnant woman)	This indicator is used when providing services to pregnant women
6	Nursing facility client	This indicator is used when providing services to nursing facility residents

- Unless otherwise stated, all paper claims must be mailed to the following address:
 Claims Processing Unit
 P.O. Box 8000
 Helena, MT 59604

Client Has Medicaid Coverage Only

Field#	Field Title	Instructions
1	Program	Check Medicaid.
1a	Insured's ID number	Leave this field blank for Medicaid only claims.
2*	Patient's name	Enter the client's name as it appears on the Medicaid client's eligibility information.
3	Patient's birth date and sex	Client's birth date in month/day/year format. Check male or female box.
5	Patient's address	Client's address.
10	Is patient's condition related to:	Check "Yes" or "No" to indicate whether employment, auto liability, or other accident involvement applies to one or more of the services described in field 24. If you answered "yes" to any of these, enter the two-letter state abbreviation where the accident occurred on the "Place" line.
10d*	Reserved for local use	Enter the client's Medicaid ID number as it appears on the client's Medicaid eligibility information.
11d*	Is there another health benefit plan?	Enter "No". If "Yes", follow claim instructions for appropriate coverage later in this chapter.
14	Date of current illness, injury, pregnancy	Enter date in month/day/year format. This field is optional for Medicaid only claims.
16	Dates patient unable to work in current occupation	If applicable, enter date in month/day/year format. This field is optional for Medicaid only claims.
17**	Name of referring physician	Enter the name of the referring physician. For PASSPORT clients, the name of the client's PASSPORT provider goes here.
17a**	ID number of referring physician	Enter the referring or ordering physician's Medicaid ID number. For PASSPORT clients, enter the client's PASSPORT provider's PASSPORT ID number.
18	Hospitalization dates related to current service	Enter dates if the medical service is furnished as a result of, or subsequent to, a related hospitalization. This field is optional for Medicaid only claims.
19	Reserved for local use	This field is used for any special messages regarding the claim or client.
20	Outside lab?	Check "No". Medicaid requires all lab tests to be billed directly by the provider who performed them.
21*	Diagnosis or nature of illness or injury	Enter the appropriate ICD-9-CM diagnosis codes. Enter up to four codes in priority order (primary, secondary, etc.).
23**	Prior authorization number	If the service requires prior authorization (PA), enter the PA number you received for this service.
24a*	Date(s) of service	Enter date(s) of service for each procedure, service, or supply.
24b*	Place of service	Enter the appropriate two-digit place of service (see <i>Appendix B</i>).
24c*	Type of service	Enter Montana's type of service code: Nursing facilities are "9", and all others are "0" (zero).
24d*	Procedure, service, or supplies	Enter the appropriate CPT-4 or HCPCS code for the procedure, service, or supply. When applicable, enter the appropriate CPT-4/HCPCS modifier. Medicaid allows up to three modifiers per procedure code.
24e*	Diagnosis code	Enter the corresponding diagnosis code reference number (1, 2, 3 or 4) from field 21 (do not enter the diagnosis code). Any combination of applicable diagnosis reference numbers may be listed on one line.
24f*	Charges	Enter your reasonable and customary charges (or the Department-designated charges) for the procedure(s) on this line.
24g*	Days or units	Enter the number of units or days for the procedure and date(s) of service billed on this line (see <i>Billing Procedures, Coding</i> for additional tips on days/units). Anesthesia providers must bill using minutes.
24h**	EPSDT/family planning	If applicable, enter the appropriate code for the client/service: 1, 2, 3, 4 or 6 (see complete description in the <i>EPSDT/Family Planning Indicators</i> table earlier in this chapter).
24i**	EMG (Emergency)	Enter an "X" if this service was rendered in a hospital emergency room to override Medicaid copay.
28*	Total charge	Enter the sum of all charges billed in field 24f.
29	Amount paid	Leave blank or enter \$0.00. Do not report any client copay or Medicaid payment amounts on this form.
30	Balance due	Enter the balance due as recorded in field 28.
31*	Signature and date	This field must contain an authorized signature and date, which is either hand signed, stamped, or computer generated.
32	Name and address of facility	Enter the name and address of the person, organization, or facility performing the services if other than the client's home or physician's office.
33*	Physician's, supplier's billing name, address, phone number	Enter the name, address, phone number and Montana Medicaid provider number (not UPIN) of the physician or supplier who furnished service.

* = Required Field

** = Required if applicable

Client Has Medicaid Coverage Only

APPROVED OMB-0938-0008

For Medicaid use. Do not write in this area.

CARRIER
PATIENT AND INSURED INFORMATION
PHYSICIAN OR SUPPLIER INFORMATION

HEALTH INSURANCE CLAIM FORM									
<div style="display: flex; justify-content: space-between;"> <div> <div style="display: flex; align-items: center;"> <input type="checkbox"/> PICA </div> <div> <div style="display: flex; justify-content: space-between;"> <div> 1. MEDICARE (Medicare #) <input checked="" type="checkbox"/> (Medicaid #) </div> <div> 2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Rhoads, Rocky </div> <div> 3. PATIENT'S BIRTH DATE MM DD YY 04 28 96 </div> <div> 4. INSURED'S NAME (Last Name, First Name, Middle Initial) </div> </div> </div> <div> <div style="display: flex; justify-content: space-between;"> <div> 5. PATIENT'S ADDRESS (No., Street) 123 Anystreet #1 </div> <div> 6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/> </div> <div> 7. INSURED'S ADDRESS (No., Street) </div> </div> </div> <div> <div style="display: flex; justify-content: space-between;"> <div> 8. PATIENT STATUS Single <input checked="" type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/> </div> <div> 9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) </div> </div> </div> <div> <div style="display: flex; justify-content: space-between;"> <div> 10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (CURRENT OR PREVIOUS) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO </div> <div> 11. INSURED'S POLICY GROUP OR FECA NUMBER </div> </div> </div> <div> <div style="display: flex; justify-content: space-between;"> <div> 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED _____ DATE _____ </div> <div> 13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED _____ </div> </div> </div> </div> </div>									

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88)

PLEASE PRINT OR TYPE

FORM HCFA-1500 (12-90), FORM RRB-1500,
FORM OWCP-1500

Client Has Medicaid and Medicare Coverage

Field#	Field Title	Instructions
1	Program	Check Medicaid.
1a*	Insured's ID number	Enter the client's Medicare ID number.
2*	Patient's name	Enter the client's name as it appears on the Medicaid client's eligibility information.
3	Patient's birth date and sex	Client's birth date in month/day/year format. Check male or female box.
4	Insured's name	Enter the name of the insured or "SAME."
5	Patient's address	Client's address.
7	Insured's address	Enter the insured's address and telephone number or "SAME."
10	Is patient's condition related to:	Check "Yes" or "No" to indicate whether employment, auto liability, or other accident involvement applies to one or more of the services described in field 24. If you answered "yes" to any of these, enter the two-letter state abbreviation where the accident occurred on the "Place" line.
10d*	Reserved for local use	Enter the client's Medicaid ID number as it appears on the client's Medicaid eligibility information.
11	Insured's policy group	This field should be blank.
11c	Insurance plan or program	This field should be blank.
11d*	Is there another health benefit plan?	Check "NO".
14	Date of current illness, injury, pregnancy	Enter date in month/day/year format.
16	Dates patient unable to work in current occupation	If applicable, enter date in month/day/year format.
17**	Name of referring physician	Enter the name of the referring physician. For PASSPORT clients, the name of the client's PASSPORT provider goes here.
17a**	ID number of referring physician	Enter the referring or ordering physician's Medicaid ID number. For PASSPORT clients, enter the client's PASSPORT provider's PASSPORT ID number.
18	Hospitalization dates related to current service	Enter dates if the medical service is furnished as a result of, or subsequent to, a related hospitalization.
19	Reserved for local use	This field is used for any special messages regarding the claim or client.
20	Outside lab?	Check "No". Medicaid requires all lab tests to be billed directly by the provider who performed them.
21*	Diagnosis or nature of illness or injury	Enter the appropriate ICD-9-CM diagnosis codes. Enter up to four codes in priority order (primary, secondary, etc.).
23**	Prior authorization number	If the service requires prior authorization (PA), enter the PA number you received for this service.
24a*	Date(s) of service	Enter date(s) of service for each procedure, service, or supply.
24b*	Place of service	Enter the appropriate two-digit place of service (see <i>Appendix B</i>).
24c*	Type of service	Enter Montana's type of service code: Nursing facilities are "9", and all others are "0" (zero).
24d*	Procedure, service, or supplies	Enter the appropriate CPT-4 or HCPCS code for the procedure, service, or supply. When applicable, enter appropriate modifiers. Medicaid recognizes two pricing and one informational modifier per code.
24e*	Diagnosis code	Enter the corresponding diagnosis code reference number (1, 2, 3 or 4) from field 21 (do not enter the diagnosis code). Any combination of applicable diagnosis reference numbers may be listed on one line.
24f*	Charges	Enter your reasonable and customary charges (or the Department-designated charges) for the procedure(s) on this line.
24g*	Days or units	Enter the number of units or days for the procedure and date(s) of service billed on this line (see <i>Billing Procedures, Coding</i> for additional tips on days/units). Anesthesia providers must bill using minutes.
24h**	EPSDT/family planning	If applicable, enter the appropriate code for the client/service: 1, 2, 3, 4 or 6 (see complete description in the <i>EPSDT/Family Planning Indicators</i> table earlier in this chapter).
24i**	EMG (Emergency)	Enter an "X" if this service was rendered in a hospital emergency room to override Medicaid copay.
28*	Total charge	Enter the sum of all charges billed in field 24f.
29	Amount paid	Leave this field blank. Do not include any adjustment amounts or coinsurance. The Medicare payment amount will be determined from the EOMB attached to the claim.
30	Balance due	Enter the balance due as listed in field 28.
31*	Signature and date	This field must contain an authorized signature and date, which can be hand signed, stamped, or computer generated.
32	Name and address of facility	Enter the name and address of the person, organization, or facility performing the services if other than the client's home or physician's office.
33*	Physician's, supplier's billing name, address, phone number	Enter the name, address, phone number and Montana Medicaid provider number (not UPIN) of the physician or supplier who furnished service.

* = Required Field

** = Required if applicable

Client Has Medicaid and Medicare Coverage

APPROVED OMB-0938-0008

For Medicaid use. Do not write in this area.

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

HEALTH INSURANCE CLAIM FORM																			
PICA																			
1. MEDICARE <input type="checkbox"/> MEDICAID <input checked="" type="checkbox"/> CHAMPUS <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN (SSN or ID) <input type="checkbox"/> FECA BLK LUNG (SSN) <input type="checkbox"/> OTHER (ID) <input type="checkbox"/>					1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1) 999999999A														
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Frost, Autumn					3. PATIENT'S BIRTH DATE MM DD YY 02 04 33 M <input type="checkbox"/> F <input checked="" type="checkbox"/>					4. INSURED'S NAME (Last Name, First Name, Middle Initial) Same									
5. PATIENT'S ADDRESS (No., Street) 4321 Anystreet					6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>					7. INSURED'S ADDRESS (No., Street) Same									
CITY Anytown					STATE MT					CITY					STATE				
ZIP CODE 59999					TELEPHONE (Include Area Code) (406) 555-9999					ZIP CODE					TELEPHONE (INCLUDE AREA CODE) ()				
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)					10. IS PATIENT'S CONDITION RELATED TO:					11. INSURED'S POLICY GROUP OR FECA NUMBER									
a. OTHER INSURED'S POLICY OR GROUP NUMBER					a. EMPLOYMENT? (CURRENT OR PREVIOUS) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					a. INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>									
b. OTHER INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>					b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					b. EMPLOYER'S NAME OR SCHOOL NAME									
c. EMPLOYER'S NAME OR SCHOOL NAME					c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					c. INSURANCE PLAN NAME OR PROGRAM NAME									
d. INSURANCE PLAN NAME OR PROGRAM NAME					10d. RESERVED FOR LOCAL USE 999999999					d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If yes, return to and complete item 9 a-d.									
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED _____ DATE _____										13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED _____									
14. DATE OF CURRENT: MM DD YY					15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY					16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY									
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE					17a. I.D. NUMBER OF REFERRING PHYSICIAN					18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY									
19. RESERVED FOR LOCAL USE					20. OUTSIDE LAB? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO \$ CHARGES					22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.									
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE) 1. 728.2 3. _____ 2. _____ 4. _____					23. PRIOR AUTHORIZATION NUMBER														
24. A DATE(S) OF SERVICE To B Place of Service C Type of Service D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) E DIAGNOSIS CODE F \$ CHARGES G DAYS OR UNITS H EPSDT Family Plan I EMG J COB K RESERVED FOR LOCAL USE																			
1 05 12 04 05 12 04 11 0 97001 1 65 00 1																			
2 05 17 04 05 17 04 11 0 97116 1 63 00 3																			
3 05 24 04 05 24 04 11 0 97542 1 50 00 2																			
4																			
5																			
6																			
25. FEDERAL TAX I.D. NUMBER SSN EIN 99-9999999 <input type="checkbox"/> <input checked="" type="checkbox"/>					26. PATIENT'S ACCOUNT NO. 999999999ABC					27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO									
28. TOTAL CHARGE \$ 178.00					29. AMOUNT PAID \$					30. BALANCE DUE \$ 178.00									
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) Susan Pullman, D.P.T. 06/15/04 SIGNED _____ DATE _____					32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)					33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE # Therapy Associates P.O. Box 999 Anytown, MT 59999 PIN# 9999999 GRP# (406) 555-5555									

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88)

PLEASE PRINT OR TYPE

FORM HCFA-1500 (12-90), FORM RRB-1500,
FORM OWCP-1500

Client Has Medicaid and Third Party Liability Coverage

Field#	Field Title	Instructions
1	Program	Check Medicaid.
1a*	Insured's ID number	Enter the client's ID number for the primary carrier.
2*	Patient's name	Enter the client's name as it appears on the Medicaid client's eligibility information.
3	Patient's birth date and sex	Client's birth date in month/day/year format. Check male or female box.
4	Insured's name	Enter the name of the insured or "SAME."
5	Patient's address	Client's address.
7	Insured's address	Enter the insured's address and telephone number or "SAME."
9 -9d	Other insured's information	Use these fields only if there are two or more third party insurance carriers (not including Medicaid and Medicare).
10	Is patient's condition related to:	Check "Yes" or "No" to indicate whether employment, auto liability, or other accident involvement applies to one or more of the services described in field 24. If you answered "yes" to any of these, enter the two-letter state abbreviation where the accident occurred on the "Place" line.
10d*	Reserved for local use	Enter the client's Medicaid ID number as it appears on the client's Medicaid eligibility information.
11	Insured's policy group	Leave this field blank, or enter the client's ID number for the primary payer.
11c*	Insurance plan or program	Enter the name of the other insurance plan or program (i.e. BlueCross BlueShield, New West, etc.).
11d*	Is there another health benefit plan?	Check "YES".
14	Date of current illness, injury, pregnancy	Enter date in month/day/year format.
16	Dates patient unable to work in current occupation	If applicable, enter date in month/day/year format.
17**	Name of referring physician	Enter the name of the referring physician. For PASSPORT clients, the name of the client's PASSPORT provider goes here.
17a**	ID number of referring physician	Enter the referring or ordering physician's Medicaid ID number. For PASSPORT clients, enter the client's PASSPORT provider's PASSPORT ID number.
18	Hospitalization dates related to current service	Enter dates if the medical service is furnished as a result of, or subsequent to, a related hospitalization.
19	Reserved for local use	This field is used for any special messages regarding the claim or client.
20	Outside lab?	Check "No". Medicaid requires all lab tests to be billed directly by the provider who performed them.
21*	Diagnosis or nature of illness or injury	Enter the appropriate ICD-9-CM diagnosis codes. Enter up to four codes in priority order (primary, secondary, etc.).
23**	Prior authorization number	If the service requires prior authorization (PA), enter the PA number you received for this service.
24a*	Date(s) of service	Enter date(s) of service for each procedure, service, or supply.
24b*	Place of service	Enter the appropriate two-digit place of service (see <i>Appendix B</i>).
24c*	Type of service	Enter Montana's type of service code: Nursing facilities are "9", and all others are "0" (zero).
24d*	Procedure, service, or supplies	Enter the appropriate CPT-4 or HCPCS code for the procedure, service, or supply. When applicable, enter appropriate modifiers. Medicaid recognizes two pricing and one informational modifier per code.
24e*	Diagnosis code	Enter the corresponding diagnosis code reference number (1, 2, 3 or 4) from field 21 (do not enter the diagnosis code). Any combination of applicable diagnosis reference numbers may be listed on one line.
24f*	Charges	Enter your reasonable and customary charges (or the Department-designated charges) for the procedure(s) on this line.
24g*	Days or units	Enter the number of units or days for the procedure and date(s) of service billed on this line (see <i>Billing Procedures, Coding</i> for additional tips on days/units). Anesthesia providers must bill using minutes.
24h**	EPSDT/family planning	If applicable, enter the appropriate code for the client/service: 1, 2, 3, 4 or 6 (see complete description in the <i>EPSDT/Family Planning Indicators</i> table earlier in this chapter).
24i**	EMG (Emergency)	Enter an "X" if this service was rendered in a hospital emergency room to override Medicaid copay.
28*	Total charge	Enter the sum of all charges billed in field 24f.
29*	Amount paid	Enter the amount paid by the other insurance. Do not include any adjustment amounts or coinsurance.
30*	Balance due	Enter the balance due (the amount in field 28 less the amount in field 29).
31*	Signature and date	This field must contain an authorized signature and date, which can be hand signed, stamped, or computer generated.
32	Name and address of facility	Enter the name and address of the person, organization, or facility performing the services if other than the client's home or physician's office.
33*	Physician's, supplier's billing name, address, phone number	Enter the name, address, phone number and Montana Medicaid provider number (not UPIN) of the physician or supplier who furnished service.

* = Required Field

** = Required if applicable

Client Has Medicaid and Third Party Liability Coverage

APPROVED OMB-0938-0008

PLEASE
DO NOT
STAPLE
IN THIS
AREA

For Medicaid use. Do not write in this area.

CARRIER
PATIENT AND INSURED INFORMATION
PHYSICIAN OR SUPPLIER INFORMATION

HEALTH INSURANCE CLAIM FORM																																																																																																																																																																																																																																																							
<div style="display: flex; justify-content: space-between;"> <div> <div> <div><input type="checkbox"/></div> PICA <div><input type="checkbox"/></div> MEDICAID <div><input type="checkbox"/></div> CHAMPUS <div><input type="checkbox"/></div> CHAMPVA <div><input type="checkbox"/></div> GROUP HEALTH PLAN (SSN or ID) <div><input type="checkbox"/></div> FECA BLK LUNG (SSN) <div><input type="checkbox"/></div> OTHER (ID) </div> <div> <div><input type="checkbox"/></div> (Medicare #) <div><input checked="" type="checkbox"/></div> (Medicaid #) <div><input type="checkbox"/></div> (Sponsor's SSN) <div><input type="checkbox"/></div> (VA File #) </div> </div> <div> <div>1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)</div> <div>999999999B</div> </div> </div>																																																																																																																																																																																																																																																							
<div>2. PATIENT'S NAME (Last Name, First Name, Middle Initial)</div> <div>Summer, Stormie</div>				<div>3. PATIENT'S BIRTH DATE</div> <div>MM DD YY</div> <div>08 31 68</div>		<div>4. INSURED'S NAME (Last Name, First Name, Middle Initial)</div> <div>Same</div>		<div>5. PATIENT'S ADDRESS (No., Street)</div> <div>4321 Anystreet</div>																																																																																																																																																																																																																																															
<div>6. PATIENT RELATIONSHIP TO INSURED</div> <div>Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/></div>				<div>7. INSURED'S ADDRESS (No., Street)</div> <div>Same</div>		<div>8. PATIENT STATUS</div> <div>Single <input checked="" type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/></div>		<div>9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)</div>																																																																																																																																																																																																																																															
<div>10. IS PATIENT'S CONDITION RELATED TO:</div> <div> <div>Employed <input type="checkbox"/> Full-Time Student <input type="checkbox"/> Part-Time Student <input type="checkbox"/></div> <div> <div><input type="checkbox"/> YES <input type="checkbox"/> NO</div> <div><input type="checkbox"/> YES <input type="checkbox"/> NO</div> <div><input type="checkbox"/> YES <input type="checkbox"/> NO</div> </div> </div>				<div>11. INSURED'S POLICY GROUP OR FECA NUMBER</div> <div>999999999B</div>		<div>12. INSURED'S DATE OF BIRTH</div> <div>MM DD YY</div> <div></div>		<div>13. EMPLOYER'S NAME OR SCHOOL NAME</div>																																																																																																																																																																																																																																															
<div>14. AUTO ACCIDENT?</div> <div><input type="checkbox"/> YES <input type="checkbox"/> NO</div>				<div>15. PLACE (State)</div> <div></div>		<div>16. INSURANCE PLAN NAME OR PROGRAM NAME</div> <div>Paywell Insurance</div>		<div>17. IS THERE ANOTHER HEALTH BENEFIT PLAN?</div> <div><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <i>If yes, return to and complete item 9 a-d.</i></div>																																																																																																																																																																																																																																															
<div>18. OTHER INSURED'S POLICY OR GROUP NUMBER</div>				<div>19. OTHER INSURED'S DATE OF BIRTH</div> <div>MM DD YY</div> <div></div>		<div>20. EMPLOYER'S NAME OR SCHOOL NAME</div>		<div>21. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.</div>																																																																																																																																																																																																																																															
<div>22. INSURANCE PLAN NAME OR PROGRAM NAME</div>				<div>23. RESERVED FOR LOCAL USE</div> <div>9999999</div>		<div>24. SIGNED</div>		<div>25. DATE</div>																																																																																																																																																																																																																																															
<div>26. READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.</div> <div>12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.</div>																																																																																																																																																																																																																																																							
<div>27. DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)</div> <div>MM DD YY</div> <div></div>				<div>28. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE</div> <div>MM DD YY</div> <div></div>		<div>29. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION</div> <div>FROM MM DD YY TO MM DD YY</div> <div></div>		<div>30. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES</div> <div>FROM MM DD YY TO MM DD YY</div> <div></div>																																																																																																																																																																																																																																															
<div>31. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE</div> <div>Smith, Steven R. MD</div>				<div>32. I.D. NUMBER OF REFERRING PHYSICIAN</div> <div>9999999</div>		<div>33. OUTSIDE LAB? \$ CHARGES</div> <div><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</div>		<div>34. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.</div>																																																																																																																																																																																																																																															
<div>35. RESERVED FOR LOCAL USE</div>				<div>36. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)</div> <div>1. 824.0</div> <div>2. </div> <div>3. </div> <div>4. </div>		<div>37. PRIOR AUTHORIZATION NUMBER</div>		<div>38. RESERVED FOR LOCAL USE</div>																																																																																																																																																																																																																																															
<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th colspan="2">A</th> <th colspan="2">B</th> <th colspan="2">C</th> <th colspan="2">D</th> <th colspan="2">E</th> <th colspan="2">F</th> <th colspan="2">G</th> <th colspan="2">H</th> <th colspan="2">I</th> <th colspan="2">J</th> <th colspan="2">K</th> </tr> <tr> <th colspan="2">DATE(S) OF SERVICE</th> <th colspan="2">To</th> <th colspan="2">Place of Service</th> <th colspan="2">Type of Service</th> <th colspan="2">PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER</th> <th colspan="2">DIAGNOSIS CODE</th> <th colspan="2">\$ CHARGES</th> <th colspan="2">DAYS OR UNITS</th> <th colspan="2">EPSDT Family Plan</th> <th colspan="2">EMG</th> <th colspan="2">COB</th> <th colspan="2">RESERVED FOR LOCAL USE</th> </tr> <tr> <th>MM</th><th>DD</th><th>YY</th><th>MM</th><th>DD</th><th>YY</th><th></th><th></th><th></th><th></th><th></th><th></th><th></th><th></th><th></th><th></th><th></th><th></th><th></th><th></th><th></th><th></th><th></th><th></th> </tr> </thead> <tbody> <tr> <td>05</td><td>03</td><td>04</td><td>05</td><td>03</td><td>04</td><td>11</td><td>0</td><td></td><td>97112</td><td></td><td></td><td>1</td><td>23</td><td>75</td><td>1</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td> </tr> <tr> <td>05</td><td>10</td><td>04</td><td>05</td><td>10</td><td>04</td><td>11</td><td>0</td><td></td><td>97116</td><td></td><td></td><td>1</td><td>21</td><td>00</td><td>1</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td> </tr> <tr> <td>05</td><td>17</td><td>04</td><td>05</td><td>17</td><td>04</td><td>11</td><td>0</td><td></td><td>97110</td><td></td><td></td><td>1</td><td>50</td><td>00</td><td>2</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td> </tr> <tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr> <tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr> <tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr> <tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr> </tbody> </table>										A		B		C		D		E		F		G		H		I		J		K		DATE(S) OF SERVICE		To		Place of Service		Type of Service		PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER		DIAGNOSIS CODE		\$ CHARGES		DAYS OR UNITS		EPSDT Family Plan		EMG		COB		RESERVED FOR LOCAL USE		MM	DD	YY	MM	DD	YY																			05	03	04	05	03	04	11	0		97112			1	23	75	1									05	10	04	05	10	04	11	0		97116			1	21	00	1									05	17	04	05	17	04	11	0		97110			1	50	00	2																																																																																																								
A		B		C		D		E		F		G		H		I		J		K																																																																																																																																																																																																																																			
DATE(S) OF SERVICE		To		Place of Service		Type of Service		PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER		DIAGNOSIS CODE		\$ CHARGES		DAYS OR UNITS		EPSDT Family Plan		EMG		COB		RESERVED FOR LOCAL USE																																																																																																																																																																																																																																	
MM	DD	YY	MM	DD	YY																																																																																																																																																																																																																																																		
05	03	04	05	03	04	11	0		97112			1	23	75	1																																																																																																																																																																																																																																								
05	10	04	05	10	04	11	0		97116			1	21	00	1																																																																																																																																																																																																																																								
05	17	04	05	17	04	11	0		97110			1	50	00	2																																																																																																																																																																																																																																								
<div>39. FEDERAL TAX I.D. NUMBER</div> <div>SSN EIN</div> <div><input type="checkbox"/></div>				<div>40. PATIENT'S ACCOUNT NO.</div>		<div>41. ACCEPT ASSIGNMENT? (For govt. claims, see back)</div> <div><input type="checkbox"/> YES <input type="checkbox"/> NO</div>		<div>42. TOTAL CHARGE</div> <div>\$ 94 75</div>		<div>43. AMOUNT PAID</div> <div>\$ 75 80</div>		<div>44. BALANCE DUE</div> <div>\$ 18 95</div>																																																																																																																																																																																																																																											
<div>45. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)</div> <div>Susan Pullman, D.P.T. 06/30/04</div>				<div>46. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)</div>		<div>47. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #</div> <div>Therapy Associates</div> <div>P.O. Box 999</div> <div>Anytown, MT 59999</div> <div>PIN# 999999 GRP# (406) 999-9999</div>																																																																																																																																																																																																																																																	

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88)

PLEASE PRINT OR TYPE

FORM HCFA-1500 (12-90), FORM RRB-1500,
FORM OWPC-1500

Client Has Medicaid, Medicare, and Third Party Liability Coverage

Field #	Field Title	Instructions
1	Program	Check Medicaid.
1a*	Insured's ID number	Enter the client's Medicare ID number.
2*	Patient's name	Enter the client's name as it appears on the Medicaid client's eligibility information.
3	Patient's birth date and sex	Client's birth date in month/day/year format. Check male or female box.
4	Insured's name	Enter the name of the insured or "SAME."
5	Patient's address	Client's address.
7	Insured's address	Enter the insured's address and telephone number or "SAME."
9 -9d	Other insured's information	Use these fields only if there are two or more third party insurance carriers (not including Medicaid and Medicare).
10	Is patient's condition related to:	Check "Yes" or "No" to indicate whether employment, auto liability, or other accident involvement applies to one or more of the services described in field 24. If you answered "yes" to any of these, enter the two-letter state abbreviation where the accident occurred on the "Place" line.
10d*	Reserved for local use	Enter the client's Medicaid ID number as it appears on the client's Medicaid eligibility information.
11*	Insured's policy group	Enter the client's primary payer (TPL) ID number.
11c*	Insurance plan or program	Enter the name of the primary payer.
11d*	Is there another health benefit plan?	Check "YES".
14	Date of current illness, injury, pregnancy	Enter date in month/day/year format.
16	Dates patient unable to work in current occupation	If applicable, enter date in month/day/year format.
17**	Name of referring physician	Enter the name of the referring physician. For PASSPORT clients, the name of the client's PASSPORT provider goes here.
17a**	ID number of referring physician	Enter the referring or ordering physician's Medicaid ID number. For PASSPORT clients, enter the client's PASSPORT provider's PASSPORT ID number.
18	Hospitalization dates related to current service	Enter dates if the medical service is furnished as a result of, or subsequent to, a related hospitalization.
19	Reserved for local use	This field is used for any special messages regarding the claim or client.
20	Outside lab?	Check "No". Medicaid requires all lab tests to be billed directly by the provider who performed them.
21*	Diagnosis or nature of illness or injury	Enter the appropriate ICD-9-CM diagnosis codes. Enter up to four codes in priority order (primary, secondary, etc.).
23**	Prior authorization number	If the service requires prior authorization (PA), enter the PA number you received for this service.
24a*	Date(s) of service	Enter date(s) of service for each procedure, service, or supply.
24b*	Place of service	Enter the appropriate two-digit place of service (see <i>Appendix B</i>).
24c*	Type of service	Enter Montana's type of service code: Nursing facilities are "9", and all others are "0" (zero).
24d*	Procedure, service, or supplies	Enter the appropriate CPT-4 or HCPCS code for the procedure, service, or supply. When applicable, enter appropriate modifiers. Medicaid recognizes two pricing and one informational modifier per code.
24e*	Diagnosis code	Enter the corresponding diagnosis code reference number (1, 2, 3 or 4) from field 21 (do not enter the diagnosis code). Any combination of applicable diagnosis reference numbers may be listed on one line.
24f*	Charges	Enter your reasonable and customary charges (or the Department-designated charges) for the procedure(s) on this line.
24g*	Days or units	Enter the number of units or days for the procedure and date(s) of service billed on this line (see <i>Billing Procedures, Coding</i> for additional tips on days/units). Anesthesia providers must bill using minutes.
24h**	EPSDT/family planning	If applicable, enter the appropriate code for the client/service: 1, 2, 3, 4 or 6 (see complete description in the <i>EPSDT/Family Planning Indicators</i> table earlier in this chapter).
24i**	EMG (Emergency)	Enter an "X" if this service was rendered in a hospital emergency room to override Medicaid copay.
28*	Total charge	Enter the sum of all charges billed in field 24f.
29*	Amount paid	Enter the amount paid by the primary payer (not Medicare). Do not include any adjustment amounts or coinsurance. The Medicare payment amount will be determined from the EOMB attached to the claim.
30*	Balance due	Enter the balance due (the amount in field 28 less the amount in field 29).
31*	Signature and date	This field must contain an authorized signature and date, which can be hand signed, stamped, or computer generated.
32	Name and address of facility	Enter the name and address of the person, organization, or facility performing the services if other than the client's home or physician's office.
33*	Physician's, supplier's billing name, address, phone number	Enter the name, address, phone number and Montana Medicaid provider number (not UPIN) of the physician or supplier who furnished service.

* = Required Field

** = Required if applicable

Client Has Medicaid, Medicare, and Third Party Liability Coverage

PLEASE
DO NOT
STAPLE
IN THIS
AREA

APPROVED OMB-0938-0008

For Medicaid use. Do not write in this area.

HEALTH INSURANCE CLAIM FORM										PICA	
1. MEDICARE <input type="checkbox"/> MEDICAID <input checked="" type="checkbox"/> CHAMPUS <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN (SSN or ID) <input type="checkbox"/> FECA BLK LUNG (SSN) <input type="checkbox"/> OTHER <input type="checkbox"/> (ID) <input type="checkbox"/>										1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Knight, Tuesday										3. PATIENT'S BIRTH DATE MM DD YY 11 07 62 SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F	
5. PATIENT'S ADDRESS (No., Street) 98765 Anystreet #2										7. INSURED'S ADDRESS (No., Street) Same	
CITY Anytown STATE MT										CITY _____ STATE _____	
ZIP CODE 59999 TELEPHONE (Include Area Code) (406) 999-9999										ZIP CODE _____ TELEPHONE (INCLUDE AREA CODE) _____	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)										11. INSURED'S POLICY GROUP OR FECA NUMBER 999999999A	
a. OTHER INSURED'S POLICY OR GROUP NUMBER										a. INSURED'S DATE OF BIRTH MM DD YY _____ SEX <input type="checkbox"/> M <input type="checkbox"/> F	
b. OTHER INSURED'S DATE OF BIRTH MM DD YY _____ SEX <input type="checkbox"/> M <input type="checkbox"/> F										b. EMPLOYER'S NAME OR SCHOOL NAME	
c. EMPLOYER'S NAME OR SCHOOL NAME										c. INSURANCE PLAN NAME OR PROGRAM NAME Paywell Insurance	
d. INSURANCE PLAN NAME OR PROGRAM NAME										d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <i>If yes, return to and complete item 9 a-d.</i>	
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED _____ DATE _____										13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED _____	
14. DATE OF CURRENT: <input type="checkbox"/> ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) MM DD YY _____										15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY _____	
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE										18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY _____ TO MM DD YY _____	
19. RESERVED FOR LOCAL USE										20. OUTSIDE LAB? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO \$ CHARGES _____	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE) 1. 722.52 3. _____ 2. _____ 4. _____										22. MEDICAID RESUBMISSION CODE _____ ORIGINAL REF. NO. _____ 23. PRIOR AUTHORIZATION NUMBER _____	
24. A DATE(S) OF SERVICE, To From DD YY MM DD YY B Place of Service C Type of Service D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER E DIAGNOSIS CODE F \$ CHARGES G DAYS OR UNITS H EPSDT Family Plan I EMG J COB K RESERVED FOR LOCAL USE											
1 05 07 04 05 07 04 11 0 97032 1 15:00 1											
2 05 07 04 05 07 04 11 0 97035 1 20:00 1											
3 05 07 04 05 07 04 11 0 97110 1 25:00 1											
4 _____											
5 _____											
6 _____											
25. FEDERAL TAX I.D. NUMBER 99-9999999 SSN EIN <input type="checkbox"/> <input checked="" type="checkbox"/>										26. PATIENT'S ACCOUNT NO.	
27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO										28. TOTAL CHARGE \$ 60:00 29. AMOUNT PAID \$ 48:00 30. BALANCE DUE \$ 12:00	
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) Mary Bender, D.P.T. 06/30/04 SIGNED _____ DATE _____										32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)	
33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE # Therapy Associates P.O. Box 999 Anytown, MT 59999 PIN# 999999 GRP# (406) 999-9999											

Client Has Medicaid, Medicare, and Medicare Supplement Coverage

Field#	Field Title	Instructions
1	Program	Check Medicaid.
1a*	Insured's ID number	Enter the client's Medicare ID number.
2*	Patient's name	Enter the client's name as it appears on the Medicaid client's eligibility information.
3	Patient's birth date and sex	Client's birth date in month/day/year format. Check male or female box.
4	Insured's name	Enter the name of the insured or "SAME."
5	Patient's address	Client's address.
7	Insured's address	Enter the insured's address and telephone number or "SAME."
9 -9d	Other insured's information	Use these fields only if there are two or more third party insurance carriers (not including Medicaid and Medicare).
10	Is patient's condition related to:	Check "Yes" or "No" to indicate whether employment, auto liability, or other accident involvement applies to one or more of the services described in field 24. If you answered "yes" to any of these, enter the two-letter state abbreviation where the accident occurred on the "Place" line.
10d*	Reserved for local use	Enter the client's Medicaid ID number as it appears on the client's Medicaid eligibility information.
11*	Insured's policy group	Enter the client's ID number for the primary payer.
11c*	Insurance plan or program	Enter the name of the other insurance plan or program (i.e. BlueCross BlueShield, New West, etc.).
11d*	Is there another health benefit plan?	Check "YES".
14	Date of current illness, injury, pregnancy	Enter date in month/day/year format.
16	Dates patient unable to work in current occupation	If applicable, enter date in month/day/year format.
17**	Name of referring physician	Enter the name of the referring physician. For PASSPORT clients, the name of the client's PASSPORT provider goes here.
17a**	ID number of referring physician	Enter the referring or ordering physician's Medicaid ID number. For PASSPORT clients, enter the client's PASSPORT provider's PASSPORT ID number.
18	Hospitalization dates related to current service	Enter dates if the medical service is furnished as a result of, or subsequent to, a related hospitalization.
19	Reserved for local use	This field is used for any special messages regarding the claim or client.
20	Outside lab?	Check "No". Medicaid requires all lab tests to be billed directly by the provider who performed them.
21*	Diagnosis or nature of illness or injury	Enter the appropriate ICD-9-CM diagnosis codes. Enter up to four codes in priority order (primary, secondary, etc.).
23**	Prior authorization number	If the service requires prior authorization (PA), enter the PA number you received for this service.
24a*	Date(s) of service	Enter date(s) of service for each procedure, service, or supply.
24b*	Place of service	Enter the appropriate two-digit place of service (see <i>Appendix B</i>).
24c*	Type of service	Enter Montana's type of service code: Nursing facilities are "9", and all others are "0" (zero).
24d*	Procedure, service, or supplies	If applicable, enter the appropriate CPT-4 or HCPCS code for the procedure, service, or supply. When applicable, enter appropriate modifiers. Medicaid recognizes two pricing and one informational modifier per code.
24e*	Diagnosis code	Enter the corresponding diagnosis code reference number (1, 2, 3 or 4) from field 21 (do not enter the diagnosis code). Any combination of applicable diagnosis reference numbers may be listed on one line.
24f*	Charges	Enter your reasonable and customary charges (or the Department-designated charges) for the procedure(s) on this line.
24g*	Days or units	Enter the number of units or days for the procedure and date(s) of service billed on this line (see <i>Billing Procedures, Coding</i> for additional tips on days/units). Anesthesia providers must bill using minutes.
24h**	EPSDT/family planning	Enter the appropriate code for the client/service: 1, 2, 3, 4 or 6 (see complete description in the <i>EPSDT/Family Planning Indicators</i> table earlier in this chapter).
24i**	EMG (Emergency)	Enter an "X" if this service was rendered in a hospital emergency room to override Medicaid copay.
28*	Total charge	Enter the sum of all charges billed in field 24f.
29*	Amount paid	Enter the amount paid by the Medicare supplement insurance only. Do not include any adjustment amounts or coinsurance. Medicare payment is determined from the EOMB attached to the claim.
30*	Balance due	Enter balance due (amount in field 28 less the amount in field 29).
31*	Signature and date	This field must contain an authorized signature and date, which can be hand signed, stamped, or computer generated.
32	Name and address of facility	Enter the name and address of the person, organization, or facility performing the services if other than the client's home or physician's office.
33*	Physician's, supplier's billing name, address, phone number	Enter the name, address, phone number and Montana Medicaid provider number (not UPIN) of the physician or supplier who furnished service.

* = Required Field

** = Required if applicable

Client Has Medicaid, Medicare, and Medicare Supplement Coverage

PLEASE
DO NOT
STAPLE
IN THIS
AREA

APPROVED OMB-0938-0008

For Medicaid use. Do not write in this area.

HEALTH INSURANCE CLAIM FORM										PICA	
1. MEDICARE <input type="checkbox"/> MEDICAID <input checked="" type="checkbox"/> CHAMPUS <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN (SSN or ID) <input type="checkbox"/> FECA BLK LUNG (SSN) <input type="checkbox"/> OTHER (ID) <input type="checkbox"/>										1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Summers, Stormie										3. PATIENT'S BIRTH DATE 05 13 33 M <input type="checkbox"/> F <input checked="" type="checkbox"/>	
5. PATIENT'S ADDRESS (No., Street) 123 Sun City Road										6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>	
7. INSURED'S ADDRESS (No., Street) Same										8. PATIENT STATUS Single <input checked="" type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) Anytown STATE MT										10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (CURRENT OR PREVIOUS) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
11. INSURED'S POLICY GROUP OR FECA NUMBER 999999999B										12. INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>	
13. INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>										14. EMPLOYER'S NAME OR SCHOOL NAME Paywell Supplemental Insurance	
15. INSURANCE PLAN NAME OR PROGRAM NAME 999999999										16. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO If yes, return to and complete item 9 a-d.	
17. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED _____ DATE _____										18. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED _____	
19. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) MM DD YY										20. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY	
21. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE 781.2										22. I.D. NUMBER OF REFERRING PHYSICIAN 1	
23. RESERVED FOR LOCAL USE										24. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY	
25. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE) 1. 781.2 3. _____ 4. _____										26. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
27. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.										28. PRIOR AUTHORIZATION NUMBER	
29. DATE(S) OF SERVICE From MM DD YY To MM DD YY										30. PLACE OF SERVICE B C D E F G H I J K	
31. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER										32. DIAGNOSIS CODE	
33. \$ CHARGES										34. DAYS OR UNITS	
35. \$ CHARGES										36. DAYS OR UNITS	
37. \$ CHARGES										38. DAYS OR UNITS	
39. \$ CHARGES										40. DAYS OR UNITS	
41. \$ CHARGES										42. DAYS OR UNITS	
43. \$ CHARGES										44. DAYS OR UNITS	
45. \$ CHARGES										46. DAYS OR UNITS	
47. \$ CHARGES										48. DAYS OR UNITS	
49. \$ CHARGES										50. DAYS OR UNITS	
51. \$ CHARGES										52. DAYS OR UNITS	
53. \$ CHARGES										54. DAYS OR UNITS	
55. \$ CHARGES										56. DAYS OR UNITS	
57. \$ CHARGES										58. DAYS OR UNITS	
59. \$ CHARGES										60. DAYS OR UNITS	
61. \$ CHARGES										62. DAYS OR UNITS	
63. \$ CHARGES										64. DAYS OR UNITS	
65. \$ CHARGES										66. DAYS OR UNITS	
67. \$ CHARGES										68. DAYS OR UNITS	
69. \$ CHARGES										70. DAYS OR UNITS	
71. \$ CHARGES										72. DAYS OR UNITS	
73. \$ CHARGES										74. DAYS OR UNITS	
75. \$ CHARGES										76. DAYS OR UNITS	
77. \$ CHARGES										78. DAYS OR UNITS	
79. \$ CHARGES										80. DAYS OR UNITS	
81. \$ CHARGES										82. DAYS OR UNITS	
83. \$ CHARGES										84. DAYS OR UNITS	
85. \$ CHARGES										86. DAYS OR UNITS	
87. \$ CHARGES										88. DAYS OR UNITS	
89. \$ CHARGES										90. DAYS OR UNITS	
91. \$ CHARGES										92. DAYS OR UNITS	
93. \$ CHARGES										94. DAYS OR UNITS	
95. \$ CHARGES										96. DAYS OR UNITS	
97. \$ CHARGES										98. DAYS OR UNITS	
99. \$ CHARGES										100. DAYS OR UNITS	
101. \$ CHARGES										102. DAYS OR UNITS	
103. \$ CHARGES										104. DAYS OR UNITS	
105. \$ CHARGES										106. DAYS OR UNITS	
107. \$ CHARGES										108. DAYS OR UNITS	
109. \$ CHARGES										110. DAYS OR UNITS	
111. \$ CHARGES										112. DAYS OR UNITS	
113. \$ CHARGES										114. DAYS OR UNITS	
115. \$ CHARGES										116. DAYS OR UNITS	
117. \$ CHARGES										118. DAYS OR UNITS	
119. \$ CHARGES										120. DAYS OR UNITS	
121. \$ CHARGES										122. DAYS OR UNITS	
123. \$ CHARGES										124. DAYS OR UNITS	
125. \$ CHARGES										126. DAYS OR UNITS	
127. \$ CHARGES										128. DAYS OR UNITS	
129. \$ CHARGES										130. DAYS OR UNITS	
131. \$ CHARGES										132. DAYS OR UNITS	
133. \$ CHARGES										134. DAYS OR UNITS	
135. \$ CHARGES										136. DAYS OR UNITS	
137. \$ CHARGES										138. DAYS OR UNITS	
139. \$ CHARGES										140. DAYS OR UNITS	
141. \$ CHARGES										142. DAYS OR UNITS	
143. \$ CHARGES										144. DAYS OR UNITS	
145. \$ CHARGES										146. DAYS OR UNITS	
147. \$ CHARGES										148. DAYS OR UNITS	
149. \$ CHARGES										150. DAYS OR UNITS	
151. \$ CHARGES										152. DAYS OR UNITS	
153. \$ CHARGES										154. DAYS OR UNITS	
155. \$ CHARGES										156. DAYS OR UNITS	
157. \$ CHARGES										158. DAYS OR UNITS	
159. \$ CHARGES										160. DAYS OR UNITS	
161. \$ CHARGES										162. DAYS OR UNITS	
163. \$ CHARGES										164. DAYS OR UNITS	
165. \$ CHARGES										166. DAYS OR UNITS	
167. \$ CHARGES										168. DAYS OR UNITS	
169. \$ CHARGES										170. DAYS OR UNITS	
171. \$ CHARGES										172. DAYS OR UNITS	
173. \$ CHARGES										174. DAYS OR UNITS	
175. \$ CHARGES										176. DAYS OR UNITS	
177. \$ CHARGES										178. DAYS OR UNITS	
179. \$ CHARGES										180. DAYS OR UNITS	
181. \$ CHARGES										182. DAYS OR UNITS	
183. \$ CHARGES										184. DAYS OR UNITS	
185. \$ CHARGES										186. DAYS OR UNITS	
187. \$ CHARGES										188. DAYS OR UNITS	
189. \$ CHARGES										190. DAYS OR UNITS	
191. \$ CHARGES										192. DAYS OR UNITS	
193. \$ CHARGES										194. DAYS OR UNITS	
195. \$ CHARGES										196. DAYS OR UNITS	
197. \$ CHARGES										198. DAYS OR UNITS	
199. \$ CHARGES										200. DAYS OR UNITS	
201. \$ CHARGES										202. DAYS OR UNITS	
203. \$ CHARGES										204. DAYS OR UNITS	
205. \$ CHARGES										206. DAYS OR UNITS	
207. \$ CHARGES										208. DAYS OR UNITS	
209. \$ CHARGES										210. DAYS OR UNITS	
211. \$ CHARGES										212. DAYS OR UNITS	
213. \$ CHARGES										214. DAYS OR UNITS	
215. \$ CHARGES										216. DAYS OR UNITS	
217. \$ CHARGES										218. DAYS OR UNITS	
219. \$ CHARGES										220. DAYS OR UNITS	
221. \$ CHARGES										222. DAYS OR UNITS	
223. \$ CHARGES										224. DAYS OR UNITS	
225. \$ CHARGES										226. DAYS OR UNITS	
227. \$ CHARGES										228. DAYS OR UNITS	
229. \$ CHARGES										230. DAYS OR UNITS	
231. \$ CHARGES										232. DAYS OR UNITS	
233. \$ CHARGES										234. DAYS OR UNITS	
235. \$ CHARGES										236. DAYS OR UNITS	
237. \$ CHARGES										238. DAYS OR UNITS	
239. \$ CHARGES										240. DAYS OR UNITS	
241. \$ CHARGES										242. DAYS OR UNITS	
243. \$ CHARGES										244. DAYS OR UNITS	
245. \$ CHARGES										246. DAYS OR UNITS	
247. \$ CHARGES										248. DAYS OR UNITS	
249. \$ CHARGES										250. DAYS OR UNITS	
251. \$ CHARGES										252. DAYS OR UNITS	
253. \$ CHARGES										254. DAYS OR UNITS	
255. \$ CHARGES										256. DAYS OR UNITS	
257. \$ CHARGES										258. DAYS OR UNITS	
259. \$ CHARGES										260. DAYS OR UNITS	
261. \$ CHARGES										262. DAYS OR UNITS	
263. \$ CHARGES										264. DAYS OR UNITS	
265. \$ CHARGES										266. DAYS OR UNITS	
267. \$ CHARGES										268. DAYS OR UNITS	
269. \$ CHARGES										270. DAYS OR UNITS	
271. \$ CHARGES										272. DAYS OR UNITS	
273. \$ CHARGES										274. DAYS OR UNITS	
275. \$ CHARGES										276. DAYS OR UNITS	
277. \$ CHARGES										278. DAYS OR UNITS	
279. \$ CHARGES										280. DAYS OR UNITS	
281. \$ CHARGES										282. DAYS OR UNITS	
283. \$ CHARGES										284. DAYS OR UNITS	
285. \$ CHARGES										286. DAYS OR UNITS	
287. \$ CHARGES										288. DAYS OR UNITS	
289. \$ CHARGES										290. DAYS OR UNITS	
291. \$ CHARGES										292. DAYS OR UNITS	
293. \$ CHARGES										294. DAYS OR UNITS	
295. \$ CHARGES										296. DAYS OR UNITS	
297. \$ CHARGES										298. DAYS OR UNITS	
299. \$ CHARGES										300. DAYS OR UNITS	
301. \$ CHARGES										302. DAYS OR UNITS	
303. \$ CHARGES										304. DAYS OR UNITS	
305. \$ CHARGES										306. DAYS OR UNITS	
307. \$ CHARGES										308. DAYS OR UNITS	
309. \$ CHARGES										310. DAYS OR UNITS	
311. \$ CHARGES										312. DAYS OR UNITS	
313. \$ CHARGES										314. DAYS OR UNITS	
315. \$ CHARGES										316. DAYS OR UNITS	
317. \$ CHARGES										318. DAYS OR UNITS	
319. \$ CHARGES										320. DAYS OR UNITS	
321. \$ CHARGES										322. DAYS OR UNITS	
323. \$ CHARGES										324. DAYS OR UNITS	
325. \$ CHARGES										326. DAYS OR UNITS	
327. \$ CHARGES										328. DAYS OR UNITS	
329. \$ CHARGES										330. DAYS OR UNITS	
331. \$ CHARGES										332. DAYS OR UNITS	
333. \$ CHARGES										334. DAYS OR UNITS	
335. \$ CHARGES										336. DAYS OR UNITS	
337. \$ CHARGES										338. DAYS OR UNITS	
339. \$ CHARGES										340. DAYS OR UNITS	
341. \$ CHARGES										342. DAYS OR UNITS	
343. \$ CHARGES										344. DAYS OR UNITS	
345. \$ CHARGES										346. DAYS OR UNITS	
347. \$ CHARGES										348. DAYS OR UNITS	
349. \$ CHARGES										350. DAYS OR UNITS	
351. \$ CHARGES										352. DAYS OR UNITS	
353. \$ CHARGES										354. DAYS OR UNITS	
355. \$ CHARGES										356. DAYS OR UNITS	
357. \$ CHARGES										358. DAYS OR UNITS	
359. \$ CHARGES										360. DAYS OR UNITS	
361. \$ CHARGES										362. DAYS OR UNITS	
363. \$ CHARGES										364. DAYS OR UNITS	
365. \$ CHARGES										366. DAYS OR UNITS	
367. \$ CHARGES										368. DAYS OR UNITS	
369. \$ CHARGES										370. DAYS OR UNITS	
371. \$ CHARGES										372. DAYS OR UNITS	
373. \$ CHARGES										374. DAYS OR UNITS	
375. \$ CHARGES										376. DAYS OR UNITS	
377. \$ CHARGES										378. DAYS OR UNITS	
379. \$ CHARGES										380. DAYS OR UNITS	
381. \$ CHARGES										382. DAYS OR UNITS	
383. \$ CHARGES										384. DAYS OR UNITS	
385. \$ CHARGES										386. DAYS OR UNITS	
387. \$ CHARGES										388. DAYS OR UNITS	
389. \$ CHARGES										390. DAYS OR UNITS	
391. \$ CHARGES										392. DAYS OR UNITS	
393. \$ CHARGES										394. DAYS OR UNITS	
395. \$ CHARGES										396. DAYS OR UNITS	
397. \$ CHARGES										398. DAYS OR UNITS	
399. \$ CHARGES										400. DAYS OR UNITS	
401. \$ CHARGES										402. DAYS OR UNITS	
403. \$ CHARGES										404. DAYS OR UNITS	
405. \$ CHARGES										406. DAYS OR UNITS	
407. \$ CHARGES										408. DAYS OR UNITS	
409. \$ CHARGES										410. DAYS OR UNITS	
411. \$ CHARGES										412. DAYS OR UNITS	
413. \$ CHARGES										414. DAYS OR UNITS	
415. \$ CHARGES										416. DAYS OR UNITS	
417. \$ CHARGES										418. DAYS OR UNITS	
419. \$ CHARGES										420. DAYS OR UNITS	
421. \$ CHARGES										422. DAYS OR UNITS	
423. \$ CHARGES										424. DAYS OR UNITS	
425. \$ CHARGES										426. DAYS OR UNITS	
427. \$ CHARGES										428. DAYS OR UNITS	
429. \$ CHARGES										430. DAYS OR UNITS	
431. \$ CHARGES										432. DAYS OR UNITS	
433. \$ CHARGES										434. DAYS OR UNITS	
435. \$ CHARGES										436. DAYS OR UNITS	
437. \$ CHARGES										438. DAYS OR UNITS	

Appendix B:

Place of Service Codes

Place of Service Codes		
Codes	Names	Descriptions
01	Pharmacy**	A facility or location where drugs and other medically related items and services are sold, dispensed, or otherwise provided directly to patients.
02	Unassigned	N/A
03	School	A facility whose primary purpose is education.
04	Homeless shelter	A facility or location whose primary purpose is to provide temporary housing to homeless individuals (e.g., emergency shelters, individual or family shelters).
05	Indian Health Service free-standing facility	A facility or location, owned and operated by the Indian Health Service, which provides diagnostic, therapeutic (surgical and non-surgical), and rehabilitation services to American Indians and Alaska Natives who do not require hospitalization.
06	Indian Health Service provider-based facility	A facility or location, owned and operated by the Indian Health Service, which provides diagnostic, therapeutic (surgical and non-surgical), and rehabilitation services rendered by, or under the supervision of, physicians to American Indians and Alaska Natives admitted as inpatients or outpatients.
07	Tribal 638 free-standing facility	A facility or location owned and operated by a federally recognized American Indian or Alaska Native tribe or tribal organization under a 638 agreement, which provides diagnostic, therapeutic (surgical and non-surgical), and rehabilitation services to tribal members who do not require hospitalization.
08	Tribal 638 provider-based facility	A facility or location owned and operated by a federally recognized American Indian or Alaska Native tribe or tribal organization under a 638 agreement, which provides diagnostic, therapeutic (surgical and non-surgical), and rehabilitation services to tribal members admitted as inpatients or outpatients.
09 - 10	Unassigned	N/A
11	Office	Location, other than a hospital, skilled nursing facility (SNF), military treatment facility, community health center, state or local public health clinic, or intermediate care facility (ICF), where the health professional routinely provides health examinations, diagnosis, and treatment of illness or injury on an ambulatory basis.
12	Home	Location, other than a hospital or other facility, where the patient receives care in a private residence.
13	Assisted living facility	Congregate residential facility with self-contained living units providing assessment of each resident's needs and on-site support 24 hours a day, 7 days a week, with the capacity to deliver or arrange for services including some health care and other services.
14	Group home	A residence, with shared living areas, where clients receive supervision and other services such as social and/or behavioral services, custodial service, and minimal services (e.g., medication administration).
15	Mobile unit	A facility/unit that moves from place-to-place equipped to provide preventive, screening, diagnostic, and/or treatment services.
16 - 19	Unassigned	N/A

Place of Service Codes (continued)		
Codes	Names	Descriptions
20	Urgent care facility	Location, distinct from a hospital emergency room, an office, or a clinic, whose purpose is to diagnose and treat illness or injury for unscheduled, ambulatory patients seeking immediate medical attention.
21	Inpatient hospital	A facility, other than psychiatric, which primarily provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services by, or under, the supervision of physicians to patients admitted for a variety of medical conditions.
22	Outpatient hospital	A portion of a hospital which provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization.
23	Emergency room - hospital	A portion of a hospital where emergency diagnosis and treatment of illness or injury is provided.
24	Ambulatory surgical center	A freestanding facility, other than a physician's office, where surgical and diagnostic services are provided on an ambulatory basis.
25	Birthing center	A facility, other than a hospital's maternity facilities or a physician's office, which provides a setting for labor, delivery, and immediate post-partum care as well as immediate care of newborn infants.
26	Military treatment facility	A medical facility operated by one or more of the uniformed services. Military treatment facility (MTF) also refers to certain former U.S. public health service (USPHS) facilities now designated as uniformed service treatment facilities (USTF).
27 - 30	Unassigned	N/A
31	Skilled nursing facility	A facility which primarily provides inpatient skilled nursing care and related services to patients who require medical, nursing, or rehabilitative services but does not provide the level of care or treatment available in a hospital.
32	Nursing facility	A facility which primarily provides to residents skilled nursing care and related services for the rehabilitation of injured, disabled, or sick person, or, on a regular basis, health-related care services above the level of custodial care to other than mentally retarded individuals.
33	Custodial care facility	A facility which provides room, board and other personal assistance services, generally on a long-term basis, and which does not include a medical component.
34	Hospice	A facility, other than a patient's home, in which palliative and supportive care for terminally ill patients and their families are provided.
35 - 40	Unassigned	N/A
41	Ambulance - land	A land vehicle specifically designed, equipped and staffed for lifesaving and transporting the sick or injured.
42	Ambulance - air or water	An air or water vehicle specifically designed, equipped and staffed for lifesaving and transporting the sick or injured.
43 - 48	Unassigned	N/A
49	Independent clinic	A location, not part of a hospital and not described by any other place of service code, that is organized and operated to provide preventive, diagnostic, therapeutic, rehabilitative, or palliative services to outpatients only.
50	Federally qualified health center	A facility located in a medically underserved area that provides Medicare beneficiaries preventive primary medical care under the general direction of a physician.
51	Inpatient psychiatric facility	A facility that provides inpatient psychiatric services for the diagnosis and treatment of mental illness on a 24-hour basis, by or under the supervision of a physician.

Place of Service Codes (continued)		
Codes	Names	Descriptions
52	Psychiatric facility -partial hospitalization	A facility for the diagnosis and treatment of mental illness that provides a planned therapeutic program for patients who do not require full time hospitalization, but who need broader programs than are possible from outpatient visits to a hospital-based or hospital-affiliated facility.
53	Community mental health center	A facility that provides the following services: outpatient services, including specialized outpatient services for children, the elderly, individuals who are chronically ill, and residents of the CMHC's mental health services area who have been discharged from inpatient treatment at a mental health facility; 24 hour a day emergency care services; day treatment, other partial hospitalization services, or psychosocial rehabilitation services: screening for patients being considered for admission to state mental health facilities to determine the appropriateness of such admission; and consultation and education services.
54	Intermediate care facility/mentally retarded	A facility which primarily provides health-related care and services above the level of custodial care to mentally retarded individuals but does not provide the level of care or treatment available in a hospital or SNF.
55	Residential substance abuse treatment facility	A facility which provides treatment for substance (alcohol and drug) abuse to live-in residents who do not require acute medical care. Services include individual and group therapy and counseling, family counseling, laboratory tests, drugs and supplies, psychological testing, and room and board.
56	Psychiatric residential treatment center	A facility or distinct part of a facility for psychiatric care which provides a total 24-hour therapeutically planned and professionally staffed group living and learning environment.
57	Non-residential substance abuse treatment facility	A location which provides treatment for substance (alcohol and drug) abuse on an ambulatory basis. Services include individual and group therapy and counseling, family counseling, laboratory tests, drugs and supplies, and psychological testing.
58 - 59	Unassigned	N/A
60	Mass immunization center	A location where providers administer pneumococcal pneumonia and influenza virus vaccinations and submit these services as electronic media claims, paper claims, or using the roster billing method. This generally takes place in a mass immunization setting, such as, a public health center, pharmacy, or mall but may include a physician office setting.
61	Comprehensive inpatient rehabilitation facility	A facility that provides comprehensive rehabilitation services under the supervision of a physician to inpatients with physical disabilities. Services include physical therapy, occupational therapy, speech pathology, social or psychological services, and orthotics and prosthetics services.
62	Comprehensive outpatient rehabilitation facility	A facility that provides comprehensive rehabilitation services under the supervision of a physician to outpatients with physical disabilities. Services include physical therapy, occupational therapy, and speech pathology services.
63 - 64	Unassigned	N/A
65	End-stage renal disease treatment facility	A facility other than a hospital, which provides dialysis treatment, maintenance, and/or training to patients or caregivers on an ambulatory or home-care basis.
66 - 70	Unassigned	N/A
71	Public health clinic	A facility maintained by either state or local health departments that provides ambulatory primary medical care under the general direction of a physician.

Place of Service Codes (continued)

Codes	Names	Descriptions
72	Rural health clinic	A certified facility which is located in a rural medically underserved area that provides ambulatory primary medical care under the general direction of a physician.
73 - 80	Unassigned	N/A
81	Independent laboratory	A laboratory certified to perform diagnostic and/or clinical tests independent of an institution or a physician's office.
82 - 98	Unassigned	N/A
99	Other place of service	Other place of service not identified above.

** Revised, effective October 1, 2005

Index

A

Absent parent	4.3
Accredited Standards Committee X12, Insurance Subcommittee (ASC X12N)	C.1
Acronyms	C.1
ACS clearinghouse	6.1
Adjustment, Adjustments	
how to request	7.7
mass	7.9
Request Form, how to complete	7.7
when to request	7.6
Administrative Rules of Montana (ARM)	C.1
Allowed amount	C.1
Ancillary provider	C.1
Assignment of benefits	4.3, C.1
Assistant/aide	2.1, C.1
Attachments to electronic bills	6.1
Augmentative communications devices	2.5
Authorization	C.1

B

Basic Medicaid	C.2
Basis of relative values	8.2
Bill, Billing	
clients directly, when providers cannot	5.2
electronically with paper attachments	6.1
errors, how to avoid	5.7, 6.3
for retroactively eligible clients	5.4
Medicaid clients, when to	5.2
Medicaid first, provider may request	4.3
third party first, exceptions	4.3
tips, PASSPORT	5.4
Bundled codes	8.3
Bundled services	5.7

C

Case records requirements	2.4
Cash option	C.2
Centers for Medicare and Medicaid Services (CMS)	C.2
Charge cap	8.3
Children's Health Insurance Plan (CHIP)	2.6, C.2

Claim, Claims

credit balance on RA	7.2
denied	7.5
denied on RA	7.2
EPSDT/Family Planning Indicators	6.2
errors, how to avoid	6.14
forms	5.1
line denied	7.6
mail to	6.2
paid on RA	7.2
pending on RA	7.2
returned	7.6
submitting	5.7
tips	6.2
Clean claims	5.1, C.2
Clearinghouse	6.1
Client	C.2
Client cost sharing	5.3
Client has Medicare	4.1
Clients with other insurance	4.1
CMS	C.2
CMS-1500	6.2
CMS-1500 Agreement	6.13
Code, Coding	
books	2.3
conventions	5.5
description, check long text	5.5
of Federal Regulations (CFR)	C.2
resources	5.6
suggestions	5.5
Coinsurance	C.2
Common billing errors	5.8
Common claim errors	6.14
Companion Guides	6.1
Composition of relative values	8.2
Conversion factor	8.2, C.2
Copayment	C.2
Cosmetic	C.2
Cost sharing	
clients who are exempt	5.3
definition	C.2
do not show when billing	5.3
how it is calculated on Medicaid claims	8.5
Coverage of specific services	2.5
Coverage, how to identify additional	4.1
Coverage, other insurance	4.1

Credit balance claims	7.2
Crime Victim's Compensation	4.3
Crossover claims to Medicaid, submit when	4.2
Crossovers, definition	C.2

D

Definitions and Acronyms	C.1
Denial, non-specific by third party	4.3
Denied claims on RA	7.2
Documentation	2.4
DPHHS, State Agency	C.2
Dual eligibles	C.3

E

Early and Periodic Screening, Diagnosis and Treatment Program (EPSDT).....	2.6, C.3
EFT, required forms	7.10
Electronic	
claims	6.1
funds transfer (EFT)	7.9
RA, required forms	7.10
remittance advice	7.1
Eligibility determination letter, attach to claim	5.4
Emergency services	C.3
EPSDT	2.6
Examples of Medicare/Medicaid payment	8.5
Exemption, how to request	4.3
Experimental	C.3

F

FA-455 Eligibility determination letter	5.4
Fee calculation	8.1
Fee schedules, how to use	5.6
Fiscal agent	C.3
Forms	5.1, A.1
Full Medicaid	C.3

G

General coverage principles	2.1
Gross adjustment	C.3
Gross adjustments on RA	7.2

H

Home Health Agencies, therapists employed by	5.4
Hospitals, therapists employed by	5.4
How modifiers change pricing	8.3
How to identify clients on PASSPORT	3.2
How to obtain PASSPORT approval	3.2

I

Implementation Guides	6.1
Indian Health Service and PASSPORT	3.2
Indian Health Services (IHS)	4.3, C.3
Individual adjustment	C.3
Individual adjustment request, how to complete	7.8
Insurance, when clients have other	4.1
Internal control number (ICN)	7.4, 7.8
Investigational	C.3

K

Key to the paper RA	7.4
Key Web Sites	ii.3

M

Maintenance therapy	C.3
Maintenance therapy plan	2.5
Manual organization	1.1
Mass adjustment	C.3
Medicaid	
definition	C.3
Eligibility and Payment System (MEPS)	C.3
payment and remittance advice	7.9
payment, when different from fee schedule	8.1
Medical coding conventions	5.5
Medically necessary	C.3
Medicare	C.4
Medicare Part B	4.2
Medicare, client has	4.1
Mental Health Services Plan (MHSP)	2.6, C.4
MEPS	7.1
Modalities	C.4
Modifiers	
how they change pricing	8.3
informational	5.7
other	8.3
pricing	5.7
Montana Breast and Cervical Cancer Health Plan (MBCCH)	C.4
Montana Eligibility and Payment System (MEPS)	7.1

N

Non-covered services	2.2
Notice on RA	7.2
Notices	1.1
Nursing facilities, therapists employed by	5.4

O

Occupational, physical, and speech therapy	2.5
Order/referral	2.4
Other insurance	4.1, 5.3
Other programs	5.9

P

PA criteria for specific services	3.3
Paid claims on RA	7.2
Paper claims	6.2
Paper RA	7.1
Paper RA sections	7.2
PASSPORT	
and Indian Health Service	3.2
approval, how to get	3.2
authorization and prior authorization may be required	3.2
description	3.1
how to identify clients who are enrolled in	3.2
To Health	3.1, C.4
Payment by Medicaid, weekly or biweekly	7.9
Payment	
by report	8.3
calculated on TPL claims	8.5
how calculated on Medicare crossover claims	8.5
Pending claims on RA	7.2
Place of service	5.4
Place of service codes	B.1
Policy adjuster	8.2
Potential liability	4.3
Prior authorization (PA)	
and PASSPORT approval may be required	3.2
definition	C.4
how to obtain	3.1, 3.3,
Private pay	C.4
Professional and technical components	8.3
Provider or provider of service	C.4

Q

Qualified Medicare Beneficiary (QMB)	C.4
Questions Answered	1.2

R

RA notice	7.2
RA, electronic required forms	7.10
RA, key to the paper	7.4
RBRVS fee schedule	8.1
RBRVS status values	8.4
Reason and remark code description on RA	7.2
Rebill, Rebilling	
and adjustments	7.5
how to	7.6
when to	7.5
Reference lab billing	C.4
Referral and IHS	3.2
Relative Value Scale (RVS)	C.4
Relative Value Unit	C.4
Remittance advice (RA)	C.4
Replacement pages	1.1
Requesting an exemption	4.3
Resource-Based Relative Value Scale (RBRVS)	C.5
Response, none from third party	4.4
Restorative therapy	C.5
Retroactive eligibility	C.5
Retroactively eligible clients, billing for	5.4

S

Sanction	C.5
Sections of the paper RA	7.2
Services provided by therapists	2.1
Services within scope of practice	2.1
Services, when providers cannot deny	5.3
Site of service differential	8.2
Special Health Services (SHS)	C.5
Specific services, coverage of	2.5
Specified Low-Income Medicare Beneficiaries (SLMB)	C.5
Spending down	C.5
Splints, braces, and slings	2.6
Status codes	8.4
Suggestions for coding	5.5

T

Team Care	3.1
Therapists employed by nursing facilities, hospitals or home health agencies	5.4
Therapy service requirements (ARM 37.86.606)	2.4
Therapy limits	2.5
Third party does not respond	4.4

Third party liability (TPL)	C.5
Third party pays or denies a claim	4.4
Timely filing	5.1, 6.1, C.5
Timely filing denials, how to avoid	5.1
TPL	4.3

U

Units over 23 minutes	5.5
Units, billing for	5.5
Usual and customary	C.5

V

Virtual Human Services Pavilion (VHSP)	ii.3, C.6
--	-----------

W

Web Sites	ii.3
WINASAP	C.6
WINASAP 2003	6.1

